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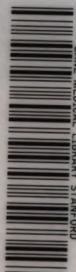
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# ANOSMIA.

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Read Before the Illinois State Medical Society

BY

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## ANOSMIA.

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An interference with, or a loss of the sense of smell is not an uncommon affection ; frequently there may be a complete suspension of it for a time, but a removal of the conditions producing it will restore it to its normal state. In some cases the interference is slight and of so little inconvenience to the patient that the fact is discovered only by accident. The sense of smell is closely allied to that of taste, however, in the determination of all flavors save bitters, sweets, acids, and salts, and if the olfactory sense has been affected to this extent, the depri-

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vation is more serious, and is no longer a matter simply of inconvenience. The anosmic patient may be exposed to certain dangers, too, from the inability to detect the presence of escaping gas, foul odors, sewer air, the odor of decaying fruits, vegetables, etc., but such a condition being recognized, proper precautions can be taken to avoid these dangers.

The olfactory area lies in the upper part of the nasal cavities. The nerves themselves spring from the under surface of the olfactory bulb which rests on the cribriform plate of the ethmoid, and are distributed to the roof of the nose, the upper third of the septum, the superior and middle turbinate bones, and the surface of the ethmoid in front of these bones. The nerve filaments do not reach the lower turbinate bodies, or the lower two-thirds of the septum.

Anosmia may be confined to one of the nasal chambers, but it is usually bilateral. In cases where it is unilateral, there may be some obstruction to the entrance of the odoriferous particles to the olfactory area. We see cases in which there is marked hypertrophy of the lower or middle turbinate body, a marked deflection of, or exostosis from the septum, or a deformity from injury with an accompanying partial loss of smell. The correction of these conditions will often remedy the defect, but they may be

of such long standing that the function of the nerves has been nearly or quite destroyed.

One of the most frequent causes is the presence of nasal polypi. When these are closely crowded in the upper portions of the nares there is always interference with, often a complete loss of the sense of smell, and it may become permanent, if the condition has been of so long duration that the nerve terminals have degenerated, and no subsequent treatment will restore them to their original integrity.

The loss can sometimes be traced directly to a severe cold, an examination of the nares revealing no abnormal conditions, save, perhaps, congestion, with slight swelling. It is usually temporary, but may become permanent.

It has been claimed that the free use of the galvano-cautery in the nasal passages has been responsible for cases of anosmia, and is a reprehensible practice for that reason. The situation of the olfactory area is in the upper part of the chamber. Cauterization, in the vast majority of cases, should be confined to the lower portions, to the inferior turbinate bodies, and the inferior two-thirds of the septum, which the filaments do not reach, and would be harmless so far as injury to the olfactory nerves is concerned. The careful use of the cautery on the middle turbinate body and the upper portions of

the nares may sometimes cause slight injury to these nerves, but its free use in the olfactory area is doubtless apt to impair, perhaps destroy the sense of smell completely.

It is not improbable that the use of many strong or caustic applications in the nasal passages has caused anosmia. A rhinitis, simple or syphilitic, may so involve the glands of the Schneiderian membrane that it becomes dry, or there may be an alteration in the secretions to such an extent that there is no longer sufficient fluid to dissolve the odoriferous particles when they come in contact with the olfactory area. Other causes are long continued contact with foul odors, paraiysis of the fifth or seventh nerve, brain disease, etc. In some cases I believe there is a congenital defect. I have observed several members of a family in whom the sense of smell was either impaired or altogether wanting.

Dr. E. Fletcher Ingals has had an interesting case under observation for several years. Mucous polypi were present and were removed when the patient was first seen, and there has been subsequent treatment with the galvano-cautery, and operations for the removal of nasal obstruction. The lady suffers from the complete suspension of the senses of smell and taste, but at times, for an instant perhaps, sometimes for two or

three hours, they return fully, only to disappear again completely. She sometimes sits down to dine in the full possession of the senses of taste and smell, but loses them before the meal is finished. There is now no nasal obstruction and the nares are in a fairly healthy condition.

Anosmia resulting from an injury is very rare. The following case recently came under my observation:

R. L. P., aged 27, a school teacher by profession, was thrown from a wagon about Nov. 5, 1886. He remembers being struck on the side of the head by the rim of the wheel in his descent. He was left lying in the middle of the road until friends reached him, about three-quarters of an hour after the accident. He was unconscious, and remained so for nine days, being treated during that period by hypodermics of morphia. When he returned to consciousness he discovered that he had lost the sense of smell completely. He was weak during the winter and suffered from marked loss of memory. Hearing was defective, especially in the right ear. He suffered also from severe frontal headaches. These continued for a year and he has had them occasionally since that time. The memory is now as good as before the accident, but it became necessary to learn again many things he had known perfectly before. His hearing has been fully restored. He had an injury to one eye 22 years ago, and it was removed about a year ago, as the other eye was becoming affected. Recovery from the operation and result are

perfect. Before his fall the sense of smell was normal. It has not been restored. He cannot distinguish the strongest odors. Aqua ammoniac fortior causes simply a slight tingling sensation in the nose. Foul odors can often be distinguished by the sickening sensation caused, and depressing headaches follow long continued contact with them. Examination of the nose shows no abnormal conditions to account for the anosmia. The sense of taste is not acute, but he can distinguish marked flavors, those of a delicate nature making no impression. His general health is perfect and has been with the exception of the year succeeding the accident. There is a slight depression in the mastoid portion of the temporal bone one and one-fourth inches behind, and a little above the external auditory meatus. He says there was simply a discolored spot here after the injury, but no fracture was discovered, and there were no other marks about the head.

No treatment has been suggested that will relieve a case of true anosmia. If dependent upon local conditions, as deformity of nasal structure, excessive hypertrophy, or nasal polypi, surgical measures may result in complete, or at least partial relief. If there has been an obliteration of the function by the presence of polypi for a number of years there is little hope of its restoration. In a nasal catarrh of two or three years standing, associated with an anosmic condition, the latter invariably becomes per-

manent. Where the sense is blunted Mackenzie recommends a remedy, suggested originally by Althaus, strychnia in doses of grs.  $\frac{1}{24}$  to  $\frac{1}{12}$ , combined with two grains of starch as an insufflation, twice a day. Other drugs have been tried, but with little success. When anosmia is symptomatic, as in some cases of brain disease, or when there has been degeneration of the nerve itself, no treatment is of any avail. In the case noted in this article there may have been a sufficient displacement of the bulb to sever its connection with the nerve filaments, or a destruction of the integrity of the bulb itself, and no relief could be expected from treatment. Some authors advise the use of the galvanic current, but with the majority of those who have used it the results have not been satisfactory. In the hands of a few there has been some success in the use of a mild Faradic current. Bosworth suggests the employment of agreeable odors, as powerful as can be obtained, changing them frequently, thus stimulating the enfeebled nerves into functional activity.

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